BRIGHT SMILES–BRETT CLIFTON, DDS
FINANCIAL, APPOINTMENT, & TREATMENT POLICY

We are committed to providing you with the best possible care and to a trusting partnership with you in your dental care. Your clear understanding of our financial and appointment policies is important to our professional relationship. Please ask if you have any questions at any time.

TREATMENT CONSENT
The undersigned hereby authorizes Brett Clifton, DDS, to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Clifton to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Clifton to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

YOUR PAYMENT IS DUE AT TIME OF TREATMENT
Payment is due at the time services are rendered. Payment for all laboratory fabricated dental treatment (crowns, onlays, bridges, dentures, etc.) is required at the time services are initiated. We accept most major credit cards, personal checks, money orders, or cash. If you prefer a deferred payment option, we offer our patients Care Credit. We have Care Credit's phone number and website for you to make financial arrangements.

DENTAL BENEFITS (Insurance)—We go the extra mile
If you have dental benefits, we will make a good faith estimate of your benefits. At the time services are rendered, patients will need to pay their estimated portion and we will defer billing to you for the remaining amount. As a courtesy to you, we will file the appropriate claim forms with your dental benefits company. We are also happy to provide your benefit carrier with x-rays or other information they may require in accordance with the Health Insurance Portability & Accountability Act (HIPAA).
If your dental benefit carrier denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your benefits carrier and/or your employer and your benefits provider.

APPOINTMENTS
Please help us serve you and our other patients by keeping your scheduled appointments. We do require a minimum of 24 HOURS NOTICE for any scheduling changes. There will be a broken appointment charge of $75 per each hour of scheduled time. This fee must be paid before scheduling any future appointments.

I understand that any delinquent balances are subject to a Finance Charge of 1 ½ % every month until balance is paid in full. Regardless of dental benefit coverage, I am responsible to pay reasonable attorney's fees and collection expenses incurred in the event my account is referred to an attorney or agency for collection.

ASSIGNMENT AND RELEASE
I authorize payment to be made directly to the dentist by my dental benefit company. I accept financial responsibility for all services whether covered or not by my dental benefit provider and I authorize release of any dental or medical care information requested by my benefit carrier.
I have read and understand the terms of my dental insurance, their policies and copayments.
Thank you for understanding our Financial & Appointment Policy. Please let us know if you have any questions.

Patient Signature	Printed Name	Date
Responsible Party Signature if different than Patient	Printed Name	Date

PATIENT MEDICAL HISTORY

Name_____ Home Phone (___)_____
Last First Middle Work Phone (___)_____
Date of Birth___/___/_____ SS#_____ Sex: M F Height_____Weight_____
Closest Relative_____Relationship to Patient_____Phone_____
Family Physician_____Address_____Phone_____
Date of last physical exam_____
Who is your general dentist?_____Orthodontist?_____
Who referred you to our office?_____

Please circle if you now have or previously have had any of the following:

Heart Disease	Low Blood Pressure	Psychiatric Treatment	Arthritis
Heart Attack	Bleeding Disorder	Immune System Problems	Anemia
Chest Pain (Angina)	Liver Disease	Fainting	Asthma
Heart Murmur	Hepatitis	Convulsions	Glaucoma
Congenital Heart Defect	Jaundice	Seizures	Thyroid Disease
Rheumatic Fever	Stomach Ulcer	Allergies	Kidney Disease
Rheumatic Heart Disease	Tuberculosis	Diabetes	Cancer
High Blood Pressure	Shortness of Breath	Sinusitis	Artificial Joints
History of TMJ popping pain (Right____Left____)		Problems with Healing_____	

Comments on above:_____

Please circle if you are allergic or have had a reaction to any of the following:

Local Anesthetics	Penicillin or other antibiotics	Iodine	Latex
Barbiturates	Aspirin	Other_____	
Codeine or other narcotics	Sulfa Drugs	Foods_____	

Please list your current medications including non-prescription medications:_____

Have you had any serious illness, operation, or been hospitalized in the past 5 years?_____
If so, explain briefly._____
Are you currently under the care o a doctor for any condition? (List)_____
Have you ever used or do you use any street drugs? (List)_____
Have you ever smoked, dipped or chewed tobacco?_____
Do you drink alcoholic beverages?_____

Female – Are you pregnant or nursing?_____Due date_____Obstetrician_____
Are you taking birth control pills?_____
Have you had any serious trouble associated with previous dental treatment?_____
Do you have any disease, condition, or problem no listed above that you think I should know about?_____
If so, explain briefly_____
Do you have any medical issues that you wish to discuss privately with your doctor?_____
What kind of problem are you having today? _____

The signature below represents my agreement to the following: I have answered all of the questions above truthfully and have revealed my complete medical history to the Doctors and staff of Oral & Facial Surgery of the Shoals, L.L.C. I will not hold my doctor, or any other member of his staff responsible for my error or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient of Legal Guardian Date

Reviewed by:_____ Physician:_____ Date Reviewed:_____